Thank you for your interest in Bridges to Care. The purpose of this program is to provide access to affordable healthcare to Davidson County's uninsured population.

To be eligible for Bridges to Care, you must:

- **be uninsured (have NO form of health insurance)**

AND

- **live in Davidson County (Nashville area)**

You are eligible for Bridges to Care regardless of your income as long as you are an uninsured resident of Davidson County.

To sign up for Bridges to Care, you must:

- **Fill out the attached application packet** *(includes application, authorization and income/residency verification) and leave it with the person who provided the packet to you, mail it to Bridges To Care at 10 S. 6th St., Nashville, TN 37206, fax it to 760-2796 or bring it yourself to a Care Coordinator (call 760-2799 for locations).*

- **Have a conversation with a Care Coordinator** *either in person or on the telephone. The Care Coordinator will complete a brief patient assessment with you and help you select the most appropriate medical home. Please note: YOU WILL NOT BE ENROLLED IN BRIDGES TO CARE WITHOUT SPEAKING TO A CARE COORDINATOR (call 760-2799 to speak to a Care Coordinator).*

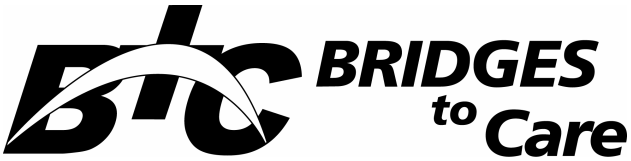
- **Provide Income and Residency Verification.** *You can do this in one of three ways: 1) attach it to your application package and return it to the person who provided the packet to you* (See attached form for acceptable forms of verification), *2) take a copy to a Care Coordinator at one of our enrollment locations, 3) mail it to the Bridges To Care office at 10 S. 6th St., Nashville, TN 37206, or 4) fax it to 760-2796.*

- *Please call 760-2799 to find the enrollment location nearest you.*

BRIDGES TO CARE IS NOT INSURANCE AND DOES NOT PAY MEDICAL BILLS.

FOR MORE INFORMATION OR TO SPEAK TO A CARE COORDINATOR PLEASE CALL 760-2799

☐ Entered



Nashville Consortium of Safety Net Providers

Application

The following information is required for participation in Bridges to Care. Please complete each item. If you do not understand any of the items, please ask for help.

Name: First	Middle	Last			
Mother's Maiden Name	Parent/Guardian Name (if patient is a minor)				
Street Address Apt. #	City	State	Zip Code		
Mailing Address (if different)					
Phone Number ( ) -	Name and phone number of person to contact in an emergency ( ) -				
Birth Date month/day/year	Age	Sex	Race (Circle One) Black White Asian Native American Pacific Islander		
Hispanic ? Yes No	Primary Language	Speak English? Yes No	Read and Write ? Yes No	Last Grade Completed?	
Years Lived In Nashville	Homeless ? Yes No	Country of Origin	County of Current Residence		
The following information is required to determine eligibility for some medical and dental services.					
Social Security Number	# in Family	Annual Family Income	Cash Assets	Hours worked per week	
Family Status (check marital status and children's ages if any) Married ❑ Single ❑		No Children ❑	Children under 6 ❑	Children over 6 ❑	

If you have children in your household for which you are the parent or guardian, please supply information about each child on the reverse side of this form.

This application cannot be accepted without a signed BTC patient release of information form. Please sign two BTC patient release of information forms. Give this completed application along with the release forms to the admission or check out desk.

If you have questions, call the BTC office at 760-2799. Thank you for participating in Bridges to Care.

Please provide this information for each child in your family household.

Name: First	Middle	Last		
Birth Date month/day/year	Age	Sex	Race (Circle One) Black White Asian Native American Pacific Islander	
Hispanic ? Yes No	Primary Language	Speak English? Yes No	Read and Write ? Yes No	Last Grade Completed?
Social Security Number				

Name: First	Middle	Last		
Birth Date month/day/year	Age	Sex	Race (Circle One) Black White Asian Native American Pacific Islander	
Hispanic ? Yes No	Primary Language	Speak English? Yes No	Read and Write ? Yes No	Last Grade Completed?
Social Security Number				

Name: First	Middle	Last		
Birth Date month/day/year	Age	Sex	Race (Circle One) Black White Asian Native American Pacific Islander	
Hispanic ? Yes No	Primary Language	Speak English? Yes No	Read and Write ? Yes No	Last Grade Completed?
Social Security Number				

Name: First	Middle	Last		
Birth Date month/day/year	Age	Sex	Race (Circle One) Black White Asian Native American Pacific Islander	
Hispanic ? Yes No	Primary Language	Speak English? Yes No	Read and Write ? Yes No	Last Grade Completed?
Social Security Number				

Income and Residency Verification Form

Please fill in the information requested and sign below. Be sure to also attach a copy of your income and residency verification.

First Name: _____ Social Security Number: _____

Last Name: _____ Number in Family: _____

Income Amount: _____ County of Residence: _____

Income Is: (Circle one)
Annually
Quarterly
Monthly
Weekly
Bi-monthly (24 pay periods/year)
Every Two weeks (26 pay periods/year)

Income Verification Source: (Circle one)
Copy of Court Order (Child Support)
Employer Income Statement
Bank Statement
Check Stub from Employer
Labor and Workforce Development Statement
Government Program Award Letter
Investment Statement
Social Security Benefit Statement
SSI/Disability Statement
Tax Return from Previous Year
Original Notarized Letter of Support

Residency Verification Source: (cannot accept expired documents)
Driver's License
Voter's Registration Card
Mortgage Statement/book
Homeowners/Renters Insurance
Check Stub from Employer (addressed to you)
Property Tax Statement
Rent receipts
Mail addressed to you (i.e., a utility bill)
Original Notarized Letter of Support

I certify the above is true and valid information to the best of my knowledge.

Signature: _____ Date: _____

Care Coordinator: _____ Date: _____

Patient Assessment

How long has it been since you last visited a Doctor? (Circle one)

Never 1 to 12 Months Ago More than a Year Don't Know

Do you have any existing medical conditions? If yes, please list them below? Yes No

_____

_____

Are you currently taking or awaiting any medications/prescriptions? Yes No
If yes, please list the medications/prescriptions:

_____

Is there a clinic or doctor you normally go to when seeking medical care? Yes No
If yes, please list the name(s) and/or clinic(s) you go to:

_____

Have you ever been admitted to a hospital? Yes No

1. Hospital:_____ Reason:_____ Date:_____

2. Hospital:_____ Reason:_____ Date:_____

What dentist/clinic do you normally go to for dental care, if any?

_____

Do you have any existing dental problems? Yes No If yes, please list:

_____

How long has it been since you last visited a dentist?

More than a Year Ago 6 to 12 Months Ago Within the Past 6 Months Never

When did you last have your teeth cleaned?

More than a Year Ago 6 to 12 Months Ago Within the Past 6 Months Never

When was the last time you had 4 or 5 drinks on one occasion?

Never In the last Six Months More Than 6 Months Ago

How often do you usually drink?

Never Once a Week Two or More Times a Week

Have you ever used illegal drugs or prescription drugs other than prescribed?

Never Within the past Year More than a Year Ago

Have you ever felt you ought to cut down on your drinking or drug use?

Yes No

Have people annoyed you by criticizing/complaining about your drinking or drug use?

Yes No

Have you ever felt bad or guilty about your drinking or drug use?

Yes No

Have you ever had a drink or drug in the morning as an eye opener to steady your nerves or get rid of a hangover?

Yes No

Have you ever been treated by a mental health professional (psychiatrist, psychologist or therapist) or prescribed medication for psychiatric or emotional problems?

Yes No

Have you ever been prescribed medication for psychiatric or emotional problems?

Yes No If yes, what?_____

Have you been troubled or bothered by psychological or emotional problems in the last thirty days?

Yes No

Have you ever been so sad that you thought of taking your own life / attempting suicide?

Yes No If yes, when?_____

Have you ever been so angry or resentful that you felt like hurting someone else?

Yes No If yes, when?_____

Have you ever heard noises or voices or seen things that others said they could not hear or see?

Yes No If yes, when?_____

Nashville Consortium of Safety Net Providers

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this Authorization, I, _____, authorize member organizations of the Nashville Consortium of Safety Net Providers (hereinafter "Consortium") to use or disclose my health information as described below.

- ***Information that is covered by this Authorization***. Health information about me that is subject to this Authorization includes all health information about me that is created or received by member organizations of the Consortium, except for the following:

  _____

- ***Entity authorized to use or disclose my health information.*** Matthew Walker Comprehensive Health Center, Centerstone Community Mental Health Centers, Metropolitan Nashville General Hospital, Meharry Medical College, Metropolitan Public Health Department, Comprehensive Care Center, United Neighborhood Health Services, Faith Family Health Center, Baptist Hospital, Buffalo Valley Treatment Center, Centennial Medical Center, Samaritan Recovery Community, Saint Thomas Health Services, Pathfinders Incorporated, Tennessee Christian Medical Center, Mental Health Cooperative, Southern Hills Medical Center, Skyline Medical Center, Summit Medical Center, LifeCare Family Services, Foundations, Vanderbilt University Medical Center, Meharry-Vanderbilt Alliance, Interfaith Dental Clinic, Siloam Family Health Center, and Catholic Charities of Tennessee (hereinafter "Providers") are authorized to use or disclose health information about me.

- ***Receiver of my health information.*** All Providers are authorized to receive health information about me.

- ***Purpose of use or disclosure of my health information***. Providers are authorized to use or disclose health information about me for the term of this Authorization for the purpose of sharing health information about me for Bridges to Care. Bridges to Care has established an electronic system for the purposes of receiving, storing, and sharing health care information among Providers in order to create a common medical record for me. Since Providers all participate in Bridges to Care, I am authorizing Providers to use, disclose, or receive my health information to or from Bridges to Care or other Bridges to Care providers for purposes of creating or accessing my common medical record.

- ***Term of the Authorization***. This Authorization will remain in effect until the Bridges to Care program no longer serves uninsured persons or unless it is revoked by me.

I understand that once Providers discloses my health information to a third party, any redisclosures of my health information by such third party may no longer be protected under federal or state privacy laws. However, any recipient of information relating to substance abuse may be prohibited from disclosing this substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I understand that I may at any time make a written request to Providers to inspect and/or obtain a copy of my health information and that Providers will within thirty (30) days of receiving this written request, either contact me for a convenient time to inspect and/or copy my health information or provide me with copies or a summary of my health information.

I understand that I may refuse to sign this Authorization at any time for any reason and that my refusal to sign this Authorization will not affect the commencement, continuation, or quality of treatment of me by Providers.

I understand that Providers will not sell or receive compensation for the use or disclosure of my health information.

I understand that I may revoke this Authorization at any time and that such revocation will not affect the commencement, continuation, or quality of treatment of me by Providers. In order to revoke my Authorization, I understand that I should obtain a Revocation Notice from the Privacy Office at the Metro Public Health Department and submit a completed Revocation Notice to the Metropolitan Public Health Department. I understand I may also revoke this Authorization by submitting a request to revoke in writing to the Privacy Office at the Metropolitan Public Health Department. This revocation will be effective immediately upon receipt of the Revocation Form or written request to revoke by Providers, except that the Revocation will not have any effect on action taken by Providers in reliance on this Authorization before it received the Revocation Form or written request to revoke.

I understand that I may contact the Privacy Office for Bridges to Care at:

ADDRESS Metropolitan Public Health Department; 311 23rd Avenue North, Nashville, TN 37203
PHONE NUMBER 615-340-5679
FAX 615-340-5665
EMAIL tonya.ruttlen@nashville.gov

I understand that this Authorization will remain in effect until its term expires or I submit a Revocation Form or written request to revoke to Providers at the address listed above.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. Accordingly, I knowingly and voluntarily authorize Providers to use or disclose my health information in the manner described above.

_____ _____
Signature of Patient Date

If Patient is a minor or otherwise unable to sign this Authorization, please complete the information below:

_____ _____ _____
Signature of Authorized Personal Representative Relationship Date

_____
Printed Name of Authorized Personal Representative

_____ _____
Witness Date

A COPY OF THIS SIGNED AUTHORIZATION WILL BE PROVIDED TO PATIENT